OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

Jakafi® and Jakafi XR™ (ruxolitinib) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

Pharmacy billing (NDC:_____) Start Date (or date of next dose):_____

Dose:_____ Regimen:_____

Billing Provider Information

Pharmacy NPI:_____ Pharmacy Name:_____

Pharmacy Phone:_____ Pharmacy Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

For Initial Authorization:

1. **Please indicate the diagnosis and information:**

☐ **Graft-Versus-Host Disease (GVHD)**

a. Is diagnosis acute or chronic GVHD? Yes☐ No☐

b. Has the member failed at least 1 prior systemic therapy? Yes☐ No☐

☐ **Myelofibrosis (MF)**

a. Will ruxolitinib be used for symptomatic lower-risk MF with no response or loss of response to peginterferon alfa-2a or hydroxyurea? Yes☐ No☐

b. Will ruxolitinib be used for intermediate to high-risk MF? Yes☐ No☐

☐ **Polycythemia Vera**

a. Has member had an inadequate response or loss of response to hydroxyurea or peginterferon alfa-2a therapy? Yes☐ No☐

☐ **If diagnosis is not listed above, please indicate diagnosis:**_____

Additional Information:_____

_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on ruxolitinib? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to ruxolitinib therapy? Yes☐ No☐

*If yes, please specify adverse reactions:*_____

Prescriber Signature:_____ Date:_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

DRAFT